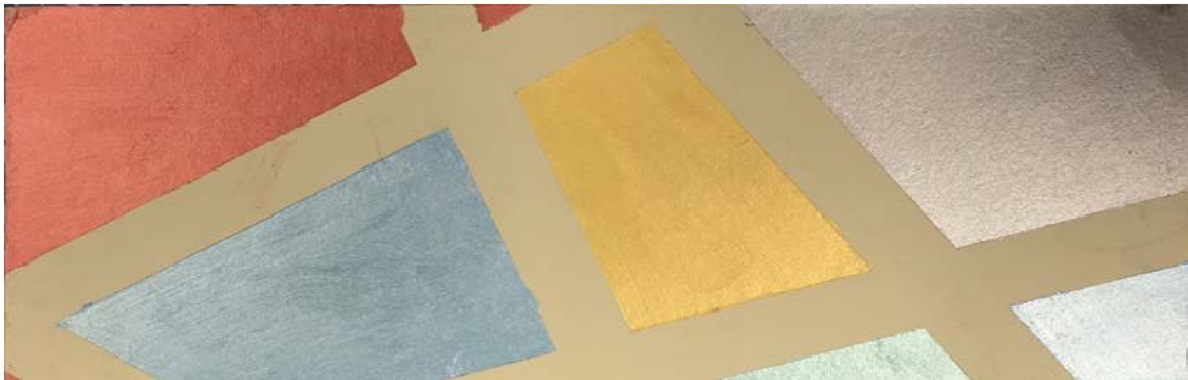

Welcome to the December 2023 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the least worst option as regards compulsory feeding, putting values properly into the mix and the need for a decision actually to be in contemplation before capacity is considered;

(2) In the Property and Affairs Report: relief from forfeiture in a very sad case;

(3) In the Practice and Procedure Report: counting the costs of delay, guidance on termination cases, and a consultation on increasing Court of Protection feeds;

(4) In the Wider Context Report: forgetting to think and paying the price, the cost of getting it wrong as litigation friend, Wales potentially striking out alone on mental health reform, and a review of Arianna's book on social care charging;

(5) In the Scotland Report: reduction of a Will: incapacity and various vitiating factors, and an update on law reform progress.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

We will be taking a break in January, so our next Report will be out in February 2024. For those who are able to take a break in December, we hope that you get the chance to rest and recuperate. For those of you who are keeping the systems going in different ways over that period, we are very grateful.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

The least worst option?

East Suffolk and North Essex NHS Foundation Trust v DL and Norfolk and Suffolk NHS Foundation Trust [2023] EWCOP 47 (Henke J)

Best interests – medical treatment

Summary[1]

In the first reported Court of Protection decision by the newly-appointed Ms Justice Henke, she considered the sad case of DL, a woman in her 30s who was detained in a psychiatric intensive care unit under s.3 Mental Health Act 1983. As Henke J noted, "*DL has a mild learning disability, complex PTSD, a dissociative disorder and an Emotionally Unstable Personality Disorder at a borderline level. She has a history of violent behaviours towards herself and others, including those caring for her*" (paragraph 6).

The judgment records at paragraph 7 that *"since about August 2023 DL has been restricting her intake of nutrition and hydration. Her current intake is incompatible with life. It is accepted by all parties before me that without intervention DL will die. All parties agree that DL wishes to live. It is the treatment plan which will sustain her life which is in dispute*." By early October 2023, DL was estimated to have a BMI of 17, and was described as emaciated and dehydrated. At that time, DL was expressing a wish to die. A consultant gastroenterologist attended on her, and considered she would be at risk of deterioration or potential death if refeeding did not start within 48 hours; it was proposed that this occur while she was sedated on a physical intensive care unit. This did not occur, and a series of meetings took place over the coming weeks, which did not result in a treatment plan for her.

This application was made on an out of hours basis on 21 October 2023 by the mental health trust (Norfolk and Suffolk Trust), though the acute Trust (East Suffolk and North Essex Foundation Trust) which would be delivering the refeeding was substituted as the applicant.

By the time of the hearing, DL was continuing to decline food and was drinking approximately 100ml water daily. It was agreed that this was not sufficient to sustain life, and DL was now consistent in her view that she wished to live; due to her continued refusal of food and the period of time she had been without food, this would require a formal refeeding plan. The court was initially invited to choose between two available options:

> *a) Restraining DL (physically and/or chemically) to insert and then maintain a NG tube in place to enable regular bolus feeding; or*
>
> *b) Feeding DL via a NG tube under general anaesthetic with an endotracheal tube being used, to prevent asphyxiation.*

[1] Note: Alex, Tor and Katie having had direct or indirect involvement in the case, they have not contributed to this note.

DL's brother and sister participated in the proceedings, and set out their support for DL to be refed under sedation. They voiced strong opposition to DL being fed via an NG tube under restraint in light of a series of hospital admissions over the last four years that DL has found traumatic. DL had also told them she wanted to 'sleep and wake up better' (a comment which she also made when meeting with the judge) which they felt was in accordance with refeeding under sedation. DL took broadly the same view as her siblings when speaking to the court, stating that she wanted to go to hospital to get better, and was very clear that she did not want to be touched or have people holding her.

The court heard from DL's responsible clinician under the Mental Health Act, a consultant gastroenterologist and a consultant in Intensive Care Medicine and Anaesthetics in the acute trust. All of these were DL's treating clinicians or those who would have responsibility for her care when the refeeding plan commenced rather than external experts. The evidence from the responsible clinician set out that refeeding DL under restraint with an NG tube would be traumatic given DL's history. The responsible clinician took the view that this proposal was unrealistic, as DL is very likely to remove tubes and cannulas repeatedly.

The clear preference of the gastroenterologist and Intensive Care consultant was to refeed DL under restraint, as they felt that DL did not require ITU-level care, that the risks of a long-term general anaesthetic to deliver re-feeding under sedation were considerable (including trauma caused by post-ITU syndrome). The intensive care consultant in particular felt that other ward-based options should be attempted before sedation under general anaesthetic to avoid a wide range of potential complications which may arise (including a significant risk of circulatory collapse and lung injury). The view of the gastroenterologist and intensive care consultant was that it was in DL's best interests to attempt a stepwise approach, and only refeed under a general anaesthetic if refeeding under restraint were unsuccessful to avoid the high risk of complications which would accompany the plan. However, the acute trust was willing to provide refeeding under sedation if the court found it to be in DL's best interests. The evidence was also clear that DL was at risk of grave harm or death if no intervention were made.

Following the evidence, the two proposed treatment plans were amended:

> *20. Shortly before court commenced on 26 October 2023, the applicant filed two fresh treatment plans. They were to be read in a linear fashion. The first was a refeeding treatment plan via a NG tube. The plan proposed elective admission to a side room on a ward of the Ipswich hospital, physical restraint to enable IV access and then initial chemical restraint /sedation to a level where DL requires minimal physical restraint. The last paragraph of the plan reads: "If DL is unable to be safely managed on the ward she will be escalated to ITU. Escalation will require sedation and a PICC line." The escalation plan to ITU confirmed deep sedation and the insertion of a PICC line to enable parenteral feeding. Both the treatment plan and escalation plan set out the benefits and burdens of each plan. I have factored those balances into my decision making.*

The acute trust continued to prefer a linear approach of attempting refeeding without a general anaesthetic, but accepted that if the court "*found the treatment plan on the ward to be as a matter of fact unmanageable, then the court could proceed to consider the escalation plan to be in DL's best interests*" (paragraph 22). The mental health set out that it was 'moving towards neutrality' on the evidence of the acute trust, but her Responsible Clinician felt that "[f]*rom a psychological perspective, Dr Axford*

considered that [the second option] *minimises the risk of further trauma for DL and maximises the welfare outcome for DL going forward*" (paragraph 23). The Official Solicitor considered that NG re-feeding under restraint would not work and was not a realistic option, and thus the second option should be pursued (also emphasising the likely traumatising impact of this option if it were pursued).

Citing *JK v A Local Mental Health Board* [2019] EWHC 679 (Fam), *A Healthcare and B NHS Trust v CC* [2020] EWHC 574 (Fam) and *An NHS Trust v Dr A* [2013] EWCOP 2442, Henke J considered "*that the Court of Protection has jurisdiction in relation to DL and is the appropriate forum for making best interest decisions in relation to the treatment proposed to feed and hydrate her*" (paragraph 27).

Henke J readily concluded that DL lacked capacity to make decisions in relation to her nutrition and hydration.

In relation to best interests, Henke J considered that the key issue was whether the proposal to refeed DL by NG tube under restraint was realistic. Henke J noted that although DL:

> *35.* […] *is weakened by her malnutrition and dehydration, she continues to be held in a segregation unit on PICU as a result of past assaultive behaviours. She has no contact with other patients because it continues to be unsafe for her to do so. In her statement dated 21 October 2023 Dr Axford's evidence, which was not challenged, was that as of that date DL was still assaulting staff members. Her aggressive behaviours mean that it continues to be unsafe to weigh DL. DL continues to need a high staff ratio.*
>
> *36. I also take into account that DL is adamant that she does not want a NG tube and that she has stated she will pull it out. DL has also forcefully stated that she does not want to be placed on a ward and that if she is placed there against her will- she will kill, kill , kill. I find that there is cogent evidence before me upon which I can and do find that there is a very real and high risk that if DL is subjected to such actions against her will, she will cause physical harm to herself and others.*
>
> *37. I also accept the evidence of DL's siblings that DL's last admission to a ward in a general hospital ended disastrously. I have no doubt the intentions at that time were good, but the effect was to cause further harm to DL.*

Henke J also noted that DL "*does not like to be touched and held. Attempting to restrain her against her will is likely to aggravate her and her presentation. Dr Axford's evidence to me was that trauma was at the root of DL's disorders. Physically restraining her is likely to trigger her responses. According to Dr Axford, attempting to treat DL under restraint simply will not work. Physical restraint will only cause DL to deteriorate. Further chemical restraint is unlikely to be of value because the drugs and dosages that can be used by reason of her frailty are unlikely to be sufficient*" (paragraph 39).

Henke J found that, while she could appreciate the views of the acute consultants in favouring an incremental approach, "[t]*here is an inevitability in this case that the treatment plan would be unmanageable from the start and the escalation plan triggered. I find that even to attempt to implement the treatment plan would present a significant risk of harm to DL. She is likely to be traumatised by the attempt which I find is highly likely to fail*" (paragraph 41).

Henke J thus adopted the second plan (as revised following the evidence) as being in DL's best interests, noting in particular the cycle of hospital admissions that DL had found to be traumatising,

and that there was "*a significant risk on the facts of this case that those events will cause additional trauma and cause DL's disorders to be aggravated and her presentation to deteriorate still further. There is a significant risk of DL being caused further psychological or psychiatric harm by any such interventions*" (paragraph 43).

Comment

The choice before the court was a stark one, in which the court had to select between two plans which medical professionals considered posed significant risks of harm to DL. The acute hospital consultants were setting out stark warnings that DL may suffer serious and lasting physical harm as a result of refeeding under sedation, including cardiac collapse and damage to her organs, and she may also suffer mental trauma from post-ITU syndrome – this was in no way the 'easy' choice for her from a medical perspective. In contrast, both her psychiatrist and family thought that she would suffer severe mental harm from the physically 'safer' option of refeeding under restraint. Henke J ultimately took the decision on the basis of the likely infeasibility of refeeding under restraint, electing to avoid what would likely be delays in the start of refeeding which would have been occasioned if the NG-feeding under restraint had been tried without success.

Placing store on values

Manchester University NHS Foundation Trust v Mr Y & Ors [2023] EWCOP 51 (John McKendrick KC, sitting as a Tier 3 Judge)

Best interests – medical treatment

Summary

A 42-year-old man was found unresponsive, brought to A&E with multiple injuries, and had a seizure necessitating intensive care. There had been prior concerns that he was not taking his antipsychotic medication for paranoid schizophrenia and, after he stabilised and returned to the ward, he was detained under s.3 of the Mental Health Act 1983. A symptom of his mental health crisis was an inability to believe what his treating clinicians were telling him.

He required surgery to treat a fractured and dislocated left shoulder, which fell outside the scope of s.63 MHA 1983, and the relevant information for deciding the matter included:

(a) the nature and purpose of the sole treatment option for his shoulder injury;

(b) that there were risks to this treatment option;

(c) the likely outcome or success of the treatment option;

(d) the potential consequences if treatment was not provided.

He was experiencing psychotic delusional beliefs and thinking that resulted in him not believing the surgery was necessary to avoid future pain and the loss of function in his left arm. The evidence clearly demonstrated that he was unable to make the decision because of paranoid schizophrenia.

As to best interests, not having the surgery would put his independence at risk for he lived alone and travelled alone to London to meet his family. Such independence was a value which he prized, and it was right that significant weight was given to that value. His brother, himself a consultant orthopaedic surgeon, supported the surgery, as did his father. John McKendrick KC went on to observe:

> *45. Lady Hale in Aintree focussed the court on the need to understand that "[t]he purpose of the best interests test is to consider matters from the patient's point of view." As she goes on to say, values can account for what is 'right' for the patient. Both values and present wishes can furnish the court with the patient's point of view. At times they may be in conflict. In an appropriate context, the patient's history may paint a picture of who they are through their lived values, more accurately than their present day wishes. That is not to discount their wishes. Each part of the picture must be considered to focus the court, as accurately as possible, on the point of view of the subject of the proceedings. In the context of a patient with recurrent severe psychiatric ill-health, their ordinary day-to-day existence may permit the court an Each part of the picture must be considered to focus the court, as accurately as possible, on the point of view of the subject of the proceedings. In the context of a patient with recurrent severe psychiatric ill-health, their ordinary day-to-day existence may permit the court an understanding of who they are and what they might want with greater clarity than their recorded wishes at the moment of crisis from a hospital bed. Giving effect to Mr Y's value of independence more effectively respects his dignity and promotes his autonomy than seeking to follow his currently expressed wishes and feelings. This underlines the importance of all parties seeking to provide the court with evidence as to who P is, as Mr Edwards helpfully sought to do.*

In conclusion, John McKendrick KC held that the surgery (including the potential need for sedative medication and restraint to administer general anaesthesia) was in the man's best interests.

Comment

What is particularly interesting about this decision is the role of values in the best interests analysis. The patient's present wishes and feelings opposed surgery, but the independence he valued so much favoured it. Reliably identifying someone's lived values, particularly in an acute situation like here, may not always be easy but consulting with family members (and significant others) often provides an insight into what they might be. For those wanting to think more deeply about values, and how to bring them fully before the court, we recommend this video from the Judging Values Project.

The need for an actual decision to be in prospect

GK & Anor v EE & Anor [2023] EWCOP 49 (MacDonaldJ)

Mental capacity – medical treatment

In this rather unusual application, MacDonald J considered the emotive subject of when parents – or indeed the courts – can intervene in the personal lives of adolescents: in this case, the life of a 17 year old, non-binary individual, EE, in conflict with their[2] parents.

The application was brought by EE's parents seeking injunctive relief in both the Court of Protection

[2] MacDonald J used a variety of pronouns in describing P, EE, in this case. He recorded in his judgment, however, that EE was non-binary and used the pronouns they/them.

and under the inherent jurisdiction of the High Court to prevent EE from having so-called "top" surgery (ie gender-affirming mastectomy) or taking testosterone treatment.

The application was unusual both because EE was almost 18 at the time of the application (and thus at the very limits of the powers of the Court exercising its Inherent Jurisdiction) but also – and most significantly – because there was no evidence that EE was in fact seeking any such surgery or hormone treatment. In fact, as MacDonald J spelled out towards the end of his judgment, *"EE has made clear, and I accept, that whilst they aspire to undergo gender affirming medical treatment, including top surgery, **there is no gender affirming medical treatment currently scheduled and nor will there be for some time**"* (paragraph 60, emphasis added).

The application was brought by EE's parents, unrepresented by the time of the final hearing, who sought orders (a) to prevent EE from having the treatment they alleged was sought, (b) for evidence from an expert psychologist and psychiatrist (unidentified at the time of the hearing) concerning EE's capacity to make decisions on gender-affirming treatment and (c) an order appointing the parents as EE's personal welfare deputies.

Underlying the application was the parents' challenged assertion that EE lacked capacity to make decisions on their treatment. The disconnect in the case presented by the parents concerning their child's past and current presentation and that presented by EE themselves and by the local authority is striking.

The parents, relying on a one-line report from their native (anonymised) country to which EE had been returned during various stages of childhood, maintained that EE suffered from a *"schizotypal personality disorder*" and/or schizophrenia and that their sexual preference (EE is reported to describe themselves as lesbian (paragraph 67) was newly announced and their purported wish to undergo treatment *"a form of self-harm"* (paragraph 33).

EE's evidence was that their parents had been aware of their sexuality since they were 11 years old but that they had stopped trying to convinced their parents about *"being a LGBT"* (paragraph 15) since they were 13 or 14. EE's evidence was that their parents were very hostile towards their sexuality and ascribed it to mental illness.

In contrast to the picture painted by the parents, the local authority, which, as of November 2022 was providing care for EE pursuant to s.20 Children Act 1989, described EE as *"a mature, independent teenager who can articulate their feelings and emotions positively"* (paragraph 22). The local authority informed the court that *"at no point have any professionals shared a concern for EE and her mental health"*.

It was in this context that the parents made an application under the inherent jurisdiction in June 2023, and in the Court of Protection by way of COP1 in July 2023, seeking an order *"preventing surgery or medical treatment in respect of gender reassignment / removal of breast in the interim"* (paragraph 57).

In response to these applications, as MacDonald J recorded at paragraph 5 of his judgment:

> *both EE and the local authority invite the court to conclude that, in circumstances where there is no gender affirming medical treatment scheduled, a decision with respect to EE's capacity to make*

decisions in that regard would be inappropriate where there is currently no "matter" for the purposes of s.2(1) of the Mental Capacity Act 2005 to be decided. In any event, both EE and the local authority submit that the evidence currently available in this case is plainly insufficient to rebut the presumption of capacity with respect to decisions concerning gender affirming medical treatment from which EE benefits pursuant to s.1(2) of the Mental Capacity Act 2005. In each of these circumstances, EE and the local authority contend it is not necessary for the court to have an expert report in the proceedings in the Court of Protection in order to determine the issue of capacity. Accordingly, both EE and the local authority invite the court to dismiss the proceedings in the Court of Protection. They further invite the court to dismiss the proceedings under the inherent jurisdiction.

MacDonald J set out the law relating to capacity, following his earlier "masterclass" in capacity, *North Bristol NHS Trust v R* [2023] EWCOP 5, in terms of the assessment of capacity, from which the following (at paragraph 45) is of particular importance:

> *It follows that "in order to determine the question of capacity under Mental Capacity Act 2005 in accordance with the legal framework set out above, **there must first be before the court a correctly identified and formulated "matter" that falls for decision proximate in time to the point at which the court determines the question of capacity**. Absent this being the position, the court is unable to satisfy itself with respect to the remaining cardinal steps of the exercise of its jurisdiction under Part 1 of the 2005 Act as summarised in the previous paragraph. Namely, what is the information relevant to the decision, is the person unable to make a decision on the matter and, if the person unable to make a decision on the matter, is that inability caused by a disturbance in the functioning of their mind or brain* (emphasis added).

In terms of jurisdiction, MacDonald J set out that s.8 Family Law Reform Act 1969 taken with the House of Lords finding in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 plus the Mental Capacity Act 2005 provided that:

1. (as set out by Sir James Munby in *NHS Trust v X [2021]* EWHC 65 (Fam), "*(1) Until the child reaches the age of 16 the relevant inquiry is as to whether the child is Gillick competent. (2) Once the child reaches the age of 16: (i) the issue of Gillick competence falls away, and (ii) the child is assumed to have legal capacity in accordance with section 8 [Family Law Reform Act 1969], unless (iii) the child is shown to lack mental capacity as defined in sections 2(1) and 3(1) of the Mental Capacity Act 2005*;"
2. Unless there is a rebuttal of the presumption of mental capacity under s.1(2) MCA 2005, whilst between the age of 16-18, P (or EE in this case) could consent to medical treatment (which would include hormone treatment or surgery if such treatment were available) under s.8 of the Family Law Reform Act;
3. Once over 18, EE could consent to treatment save in circumstances where the capacity to consent to treatment is rebutted.

MacDonald J noted that there was "*at present no cogent evidence demonstrating that EE is a young person who suffers from schizophrenia or a schizotypal personality disorder or is a young person who has issues with respect to their capacity generally*" (paragraph 67). His judgment makes clear however, that the court – whether the Court of Protection or the High Court exercising its inherent jurisdiction – had not even got to the point of having to reach conclusions as to EE's capacity to make decisions regarding

gender affirming medical treatment in circumstances where there was no evidence that any such treatment was presently proposed or available. In those circumstances he held (at paragraph 60) that:

> *I am satisfied that it is not possible in this case at present to identify the "matter" for the purposes of s.2(1) of the 2005 Act with any greater particularity than the formulation used in the parents' Annex B form, namely "surgery or medical treatment in respect of gender reassignment/ removal of breast." In my judgment, that formulation of the matter is not a sufficient basis on which to assess capacity having regard to the principles I have set out above. Further, and of equal importance, the absence of any scheduled gender affirming medical treatment necessarily means that the court would not be assessing EE's capacity in that regard sufficiently proximate in time to the decision falls to be made. For the court to make what, in effect, would be anticipatory declarations as to EE's capacity with respect to a broad category of medical treatment would run entirely contrary to the cardinal principles of the 2005 Act.*

Having reached such a conclusion, MacDonald J determined that any expert would be in entirely the same position of being unable to identify the "*matter*" on which he/she was being asked to assess EE's capacity and that any expert evidence would thus be "*unnecessary*" within the meaning of COPR 15.

Further, MacDonald J was:

> *68.* […] *satisfied in the foregoing context that it is not necessary for the purposes of Part 25 of the FPR 2010 to give permission for expert psychological and psychiatric evidence. In circumstances where the court's jurisdiction in respect of EE under the inherent jurisdiction comes to an end during September 2023, I am in any event satisfied that it would be wholly disproportionate to permit the instruction of an expert in the proceedings under the inherent jurisdiction. Having regard to the matters set out above, I further refuse to grant an injunction under the inherent jurisdiction preventing EE from undergoing gender affirming medical treatment.*

The parents' application was, unsurprisingly, dismissed.

Comment

The complex facts of this case (and the sad story they tell of family breakdown) notwithstanding, this is now a relatively well-trodden area of law.

The assessment of capacity draws back to first principles: the burden of proving a lack of capacity lies on those asserting the same; the court when assessing capacity must look at the actual decision which it is being said P is unable to make.

In circumstances where there *was in fact* no surgery or hormone treatment either in contemplation or actually available, the only conclusion that the court could draw was that there was simply no decision on which the court's assessment could "*bite*".

As to the reach of parental power, the courts have reviewed this at some length in recent years, both in *NHS Trust v X* [2021] EWHC 65 (Fam) to which MacDonald J referred, but also the Tavistock litigation, not just the Court of Appeal in *Tavistock v Bell* [2021] EWCA Civ 1363 but also the antecedent judgment of Lieven J in *AB v CD* [2021] EWHC 741 (Fam).

One point of no little interest whilst we wait for the final report of the Cass Review into gender identity

services for children and young people is MacDonald J's confirmation that gender affirming medical treatment constitutes 'medical treatment' for purposes of the Family Law Reform Act 1969. Whilst on the face of this might appear obvious, such is the controversy around these issues that it would not have been entirely surprising had the parents advanced the argument that such interventions did not constitute 'medical treatment' for purposes of the FLRA.

The interface in an hour

Those grappling with the MCA / MHA interface, in particular in the hospital setting, and wanting to think through the implications of recent cases in this area, might want to watch the recording of a recent webinar hosted by Bevan Brittan, featuring Hannah Taylor (Bevan Brittan) and Alex.

PROPERTY AND AFFAIRS

Short Note: relief from forfeiture

When a person unlawfully kills another, the "forfeiture rule" prevents that person from benefitting from the deceased person's estate. This rule is grounded in obvious public policy.

The Forfeiture Act 1982 was enacted to allow the court to grant relief from that rule if it is satisfied that, having regard to the conduct of the offender and of the deceased and to such other circumstances as appear to the court to be material, the justice of the case requires the effect of the rule to be so modified or excluded in that case.

Helpful guidance is provided in the judgment of Mummery LJ in the case of *Dunbar v Plant*, which guidance has been applied subsequently in a number of cases, and what Mummery LJ there said is that the following list of factors may be relevant in the exercise of the court's discretion:

> *The court is entitled to take into account a whole range of circumstances relevant to the discretion, quite apart from the conduct of the offender and the deceased: the relationship between them; the degree of moral culpability for what has happened; the nature and gravity of the offence; the intentions of the deceased; the size of the Estate and the value of the property in dispute; the financial position of the offender, and the moral claims and wishes of those who would be entitled to take the property on the application of the forfeiture rule.*

Further guidance is given in the case of *Ninian (Deceased)*, a decision of Chief Master Marsh. In that case the Chief Master regarded it as helpful to have regard to the DPP's policy statement relating to prosecution in relation to assisting a suicide, which was the matter with which he was concerned in the *Ninian* case, and decisions on whether or not to prosecute. The Chief Master pointed out that, although the decisions whether to prosecute and whether or not to give relief under the Forfeiture Act are different, they both involve consideration of moral culpability and the offender's motivation.

In *Withers Trust Corporation v The Estate of Hannah Goodman* [2023] EWHC 2780 (Ch) Master McQuail had to consider an application for relief where a husband had assisted in the suicide of his terminally ill wife and then, wracked with remorse, took his own life. The wills of husband and wife, who had no children, left residuary gifts to similar charitable objects though, for reasons connected with inheritance tax law, the wife's gift would have led to an inheritance tax charge (£200,000) but the husband's would not. Hence the application.

The Master considered the above guidance and found that the evidence demonstrated that the wife had a clear wish to end her own life. The Master considered the recently amended CPS guidelines on prosecution in such cases and found that a prosecution would have been very unlikely. The Master then went on to find a very low (almost no) moral culpability and, therefore, granted the relief sought.

PRACTICE AND PROCEDURE

Short note: the requirements for termination cases

The case of *A Health Board v AZ and others* [2023] EWHC 2517 (Fam) was brought in the Family Division for orders pursuant to the court's inherent jurisdiction to terminate the pregnancy of an 11 year old who had been raped at the age of 10, by a 14 year old boy she had met on the internet. She has also been the subject of a further rape by a 14 year old boy shortly after her 11th birthday.

Although the child had initially wanted to go through with the pregnancy, by the time the matter came before the court for final hearing (by which time the child was nearly 15 weeks pregnant), both her parents and the guardian were supportive of the application brought by the Health Board for a termination. The child had accepted the need for a termination, but did not want to make the decision herself. The parties were also in support of the second part of the application, namely for a declaration that some tissue could be removed from her placenta for forensic testing in a criminal investigation.

Arbuthnot J did not hear any oral evidence, but reviewed the written evidence which came from a consultant psychiatrist, and two consultant obstetricians and gynaecologists. Arbuthnot J reiterated what has been said in the previous cases of *Re AB (Termination of pregnancy)* [2019] EWCA 1215 and *Re X (A Child)* [2014] EWHC 1871, namely that there is a two stage test to be applied in such applications. The first stage is for the doctors who must consider whether the terms of s.1 Abortion Act 1967 are met. The second stage is for the court to make a best interests decision having evaluated all the material factors.

Arbuthnot J then went on to set out all the physical risks to the child of continuing with the pregnancy (which were significant) as well as the risks to the mental health of the child arising from the pregnancy, childbirth and the care of the baby. She also considered the evidence she had of the risks and benefits to the child of medical and surgical termination. In considering this evidence, Arbuthnot J held that even though the child had accepted the need for termination, it would have been helpful for there to have been a more detailed examination of the risks to her of the termination, and the arguments in favour of continuing the pregnancy. Arbuthnot J also found that it would have been more helpful to have the risks of a surgical termination set out in more detail.

One of the factors that Arbuthnot J weighed in the balance was the high likelihood (as she found), that the baby would be taken away from the child at birth.

Despite the child being thought to be at risk of getting pregnant again after the termination, there was no application before the court for an implant to be inserted at the same time as the termination was performed. As Arbuthnot J noted, both could be done under the same anaesthetic and would provide protection to the child from pregnancy for three years. The parties were hoping that the child would consent to this.

Arbuthnot J then went on to give some guidance (approved by the President) for such cases. In short this emphasises the need to bring applications early, even if they then have to be subsequently withdrawn, the need for early referrals to other statutory agencies so that consideration can be given as to whether the child meets their criteria for support and the need for multi-agency working.

The Guidance goes on to set out the evidence that should be provided to the court in any such application:

a. Written evidence from two registered medical practitioners who are able to address the requirements of s.1 Abortion Act 1967, preferably from two obstetricians;

b. Written evidence from a child and adolescent psychologist or psychiatrist who has met with the child to provide evidence on her *Gillick* competence to consent to any decisions regarding termination. It would be preferable for this evidence to be obtained in the absence of the child's mother and father.

c. A full best interests analysis by one of the two obstetricians. The focus of this analysis ought to be on the subject child and not on the foetus, consistent with the case law in *Vo v France* (2005) 10 EHRR 12; *Paton v British Pregnancy Advisory Service* [1979] QB 276; and *Paton v United Kingdom* (1980) 3 EHRR 408. The analysis ought to include:

    i. all options available;

    ii. a summary of the risks and benefits of each option;

    iii. the preferred option and the reason why it is preferred;

    iv. the applicant's position on any other consequential orders sought such as:

        1. sterilisation;

        2. contraception; or

        3. the retaining of any placenta tissue for the purposes of forensic investigation.

d. A care plan addressing the detailed logistics of the proposed treatment and the support that will be offered to the child prior to, during and following any sanctioned treatment. This support is to include mental health support where appropriate.

Comment

While this desperately sad case was an exercise by the High Court of its inherent jurisdiction relating to a child, the guidance contained within it is essential reading for anyone bringing a termination case in the Court of Protection. In particular practitioners are well advised to heed the emphasis on the need for proceedings to be brought early and for the urgency of the application to be stressed to the court to ensure a timely directions hearing and final hearing.

The case is also interesting for Arbuthnot J's consideration of the child's need for contraception, even though no such application was before the court. Practitioners would do well to consider what if any steps will be required in the future to safeguard the subject matter of the proceedings, and if possible, incorporate those within the application.

The costs of delay

Re GH (Mastectomy: Best Interests: Costs) [2023] EWCOP 50 (Poole J)

COP jurisdiction and powers – costs

Summary

This matter related to GH, who was 52 and had a diagnosis of schizoaffective disorder. The substantive application sought orders that GH should undergo breast cancer surgery which were granted. However, the case is of greater interest for its findings on costs orders in serious medical treatment cases.

GH was diagnosed with breast cancer in March 2023, shortly after being released from detention under the Mental Health Act 1983 on a Community Treatment Order. GH refused treatment for her condition. She was re-detained in May 2023 for about three weeks, at which time she felt that her cancer diagnosis was a 'cover up' to avoid her receiving compensation from the NHS. A capacity assessment was undertaken on 30 June 2023 by a psychiatrist, breast surgeon and breast nurse, who concluded that she lacked capacity (at the time, she was expressing her breast lump was due to 'black magic'). She declined any care for her condition. A view was taken that an application ought to be made to the Court of Protection, and a decision was taken to recall GH to hospital for further treatment of her schizophrenia. She was re-admitted to hospital on 27 July 2023, and told that an application would be made to the Court of Protection in respect of her breast cancer treatment in early August. A re-assessment of her capacity was undertaken on 6 September 2023, reaching the same conclusion as the June assessment.

The Court of Protection application was not made on 21 September 2023; the evidence before the court was that there was a risk that the carcinoma may have grown to such an extent that it may be inoperable. The Official Solicitor had been given notice of the proposed application towards the end of the previous week. It came before Poole J on the urgent applications list on 26 September, with the Trust seeking authorisation to carry out the proposed surgery on 27 September. The court did not conduct a full hearing on the 26th, and listed the matter for a half-day hearing on 28 September, at which time GH was found to lack capacity to make the relevant decisions and the treatment plan was found to be in her best interests. A post-script notes that the recommended surgical treatment was undertaken successfully, the carcinoma was operable and treatment was achieved without the use of restraint.

Costs

The Official Solicitor made an application for a costs order for 100% of her on the grounds of excessive delay in issuing proceedings. The Trust opposed this order. It stated that the delay had been caused by a number of factors, including GH's consultant going on long-term sick leave, its lack of control over the evidence of GH's treating psychiatrist, uncertainty about GH's capacity, and general stresses on the NHS, including industrial action.

The Official Solicitor argued that "*the delay by the Applicant Trust* [was] '*unacceptable' and as having had a number of adverse consequences including that it undermined the role of the OS herself. As early as 5 May 2023 it was recorded that GH did not appear to have capacity to make decisions about her*

treatment….The OS is concerned that in too many cases of this kind (not necessarily involving this Applicant) Trusts make very late applications, thereby undermining her role" (paragraph 55).

The Trust made two arguments in response:

1. At the outset of the proceedings, the Trust had agreed, in the standard convention for Serious Medical Treatment applications, to fund 50% of the Official Solicitor's costs. The Trust argued that the Official Solicitor now sought to withdraw from that agreement, and should not be permitted to do so.

2. In any event, there were no good reasons to depart from the general rule on costs in welfare applications, because:

> *i) Satellite costs litigation should not be encouraged in this welfare jurisdiction.*
>
> *ii) The bar should not be set too low for departing from the general rule. The pressures on NHS trusts and very busy clinicians are such that if there is a departure on the basis of delay in making applications in such cases, there will be many such applications and the conventional arrangement will be jeopardised.*
>
> *iii) If there is a departure from the general rule due to conduct, then the conduct should not only be serious, but it should have very clear costs consequences. Here the OS did not incur additional costs because of the timing of the application* (paragraph 58)

By way of framework on costs, Poole J set out s.55 MCA and COPR 19.3, 19.5, 19.6 (which incorporated by reference Parts 44, 46 and 47 CPR(with modifications as set out in the COPR)) and 19.9.

In relation to the first argument, Poole J found that the agreement of the Trust to pay 50% of the Official Solicitors costs "'*is not a formal contract and, I find, it is implicit in the agreement that, depending on the circumstances as the OS later finds them to be or as they develop, the OS may in certain cases seek a costs order for more than 50%.* […] *the Trust did not rely to its detriment on the agreement and that the OS is not estopped or otherwise prevented from seeking a greater proportion or indeed the whole of her costs*" (paragraph 57).

Poole J noted the statements of Keehan J in *An NHS Trust v FG* [2014] EWCOP 30 as to the undesirable consequences of late applications. At paragraph 61, he set out how he considered that this this case, the lateness of the application had:

> *i. Undermined the role that the OS should play in the proceedings. The importance of this should not be overlooked. The OS represents the interests of GH. The OS needs time to consider the evidence, meet GH and ascertain her wishes and views, probe the evidence, ask questions, seek independent expert evidence if necessary, liaise with GH's family, and form a view of GH's capacity and best interests. The OS does not have unlimited resources and has responsibilities in many other cases.*
>
> *ii. Placed the court under considerable pressure to find precious time, on a very urgent basis, to hear the application. There was no opportunity to give directions in relation to evidence other than within a very short period from 26 to 28 September 2023. An application of this kind is*

very unlikely to be determined within an hour. The urgent applications list will often have six or more cases, sometimes several more, to be heard within the day. If an urgent application can be avoided it should be avoided. This application only became urgent because of the delay in making it.

iii. *Risked undermining open justice - this application did not appear on the list on September 2023 because of the lateness of the application. Hence, those who might have wished to observe this important application did not have advance notice of what might have been a substantive hearing on 26 September.*

iv. *Caused disruption to the surgeons, clinicians, and staff at the Trust because the planned surgery on 27 September 2023 had to be postponed and hastily re-arranged.*

v. *Contributed to a delay in treating GH. The need for surgery was known at diagnosis on 2 March 2023. The surgery took place nearly seven months later. A key performance standard for NHS England is for a 62 day period between referral and treatment for cancer (the target being for this standard to be met in 85% of cases). For a person with capacity who had refused adjuvant chemotherapy but consented to surgery (which is effectively the corresponding position for GH following my decisions above) the target date for surgery (the first line of treatment in those circumstances) would therefore have been in late April 2023, about five months before the application was made. The consequences of the delay in treatment are unknown (but see postscript below).*

Poole J did not consider that there was any bad faith by the Trust, and accepted the difficulties which had been presented by the Trust on pressures on resources within the NHS. *"However, it must have been clear, if not in early March certainly by early May, that a Court of Protection application may well be required and that, given the nature of GH's condition and the surgery required, the delays up to that point, and the pressing need for surgery to be performed sooner rather than later, expedition was required"* (paragraph 63). The court did not accept that the reasons given by the Trust justified the delay.

Polle J accepted that the Official Solicitor would have incurred costs in any event, and likely would have incurred more costs had the application been timely, as there would have been more opportunity to work on the matter. However, Poole J found that applying CPR 44.11 (via COPR 19.6), a costs order can be made that is not entirely compensatory, even if there is not misconduct. Poole J likened the conduct of the Trust to being "*close to that of a party who has been successful in civil litigation but who had unreasonably refused to mediate,*" (paragraph 66) which has been recognised by courts "*as being conduct that justifies a departure from the usual order that costs follow the event* […] *Such costs orders will not require payment of costs over and above the costs actually incurred, but they are not purely compensatory because it cannot be known with certainty what costs would have been incurred had mediation taken place.* […] *The costs order is designed to encourage appropriate pre-issue conduct*" (paragraph 66).

Poole J found it was appropriate to deviate from the general rule on costs where the Trust's "*pre-issue conduct undermined the role of the OS and prevented pre-issue work which may or may not have helped to resolve some of the issues which the making of the application required the court to determine. Just as an unreasonable failure to mediate can justify a departure from an order that costs follow the event in civil proceedings, even if the costs incurred may have been incurred had mediation taken place, so, in my*

judgment, a failure to issue an application in the Court of Protection in relation to a question of serious medical treatment within a reasonable time, may justify a departure from the general rule as to costs even if another party's costs may not have been avoided had the application been brought timeously" (paragraph 67). Poole J considered that the Trust's conduct had also been unreasonable in "*exposing GH, whose interests the OS represents, to a risk of harm*" (paragraph 68).

In determining what costs order should be made, Poole J accepted "*that in exercising a discretion as to costs the court should consider what costs might have been incurred in any event but that is not an accounting exercise in a case such as this*" (paragraph 69). The judgment set out that there had been an existing agreement for the Trust to pay 50% of the Official Solicitor's costs in any event. Poole J considered that assessing costs as a 'broad brush' exercise, which took into account "*all the circumstances which include the degree of unreasonableness and the extent of the delay, the impact of the delay on GH and the OS, the costs actually incurred by the OS and to what extent those costs have been incurred as a result of the paying party's default. Exercising my discretion I am sure that an issue based costs order would not be appropriate and I do not have adequate information on which to make an award for a fixed amount of costs. I take into account my power to order assessment of costs on the standard or indemnity basis. In my judgment an appropriate order is for the Applicant Trust to pay 80% of the OS's costs of and occasioned by the application to be assessed on the standard basis if not agreed. An order for 100% of costs might have been made if the Trust's failings had been egregious and/or the consequences, including the costs consequences, for the OS even more serious*" (paragraph 70).

Comment

The case is a rare example of an order for costs being made against a public body in welfare proceedings. We would note the differing approaches taken by Poole J here and DHCJ Vikram Sachdeva KC in *West Hertfordshire Hospitals NHS Trust v AX (Rev 1)* [2023] EWCOP 11, on what was essentially a very similar application by the Official Solicitor for costs in a case where there were significant delays and the case was brought on an urgent basis. In the earlier case, DHCJ Sachdeva had emphasised previous case law cautioning against costs orders in welfare cases, and despite the Trust having failed to follow the guidance in *FG*, which had caused prejudice to P and impacted on the work of the Official Solicitor and court in scrutinising the application, the court found it would not have made a costs order. DHCJ Sachdeva considered that the test for departure from the general order on costs was relatively high (applying a standard in line with 'significantly unreasonable' conduct), and that the court could express disapproval of a party's case in manners other than a costs order. In both cases, the courts acknowledged the fact-specific nature of costs applications and courts considering the complete circumstances of the case, and it may be that neither case would be particularly persuasive as authority in future applications for costs.

Short note: closed contempt

In *Lincolnshire County Council v X & Ors* [2023] EWCOP 53, HHJ Tucker proceeded in the absence of respondents to a committal for contempt arising out of Court of Protection proceedings, specifically a breach of an injunction regarding contact with P. In an immediately preceding judgment, *Lincolnshire County Council v X & Ors* [2023] EWCOP 52, HHJ Tucker had acceded to an application to deviate from the norm of hearing the contempt application in public, on the basis that it was

> *60.* […] *necessary to sit in private to protect the interests of X as set out in COPR 2017 r.21.8(4)(d). Further, I consider that it is necessary to do so to secure the proper administration of justice pursuant to r.21(8). If the proceedings are not held in private I consider that part of the harm the proceedings before the Court seek to prevent would, in fact, be caused by proceedings themselves.*

HHJ Tucker did not determine the question of whether the contemnors should be named, deferring the question until after the committal hearing. She also set out the concerns of Professor Celia Kitzinger of the Open Justice Court of Protection Project as to the difficulties that members of the public have about finding out about committal hearings which are to be held in private, and noted that she would "*to provide a commitment, however, to ensuring that the practical arrangements of this Court follow* [the guidance] *set out in the Esper*" case about such matters, the case having been handed down very shortly before the hearing.

HHJ Tucker found that the respondents had "*acted with complete disregard for the Court orders, in a persistent and sustained manner. Their lack of participation in the Court proceedings and past evidence of evading service gives me little confidence that anything short of a custodial sentence will secure their compliance with the Court's Orders. In addition, I consider that the custody threshold is crossed by the breaches I have found to be proven* […]." She suspended the sentences on condition that there was complete compliance with the injunction. The contemnors not being named, it appears that HHJ Tucker must (implicitly) have reached the conclusion that they should not be.

Short note: cross-border detention

In *The Health Service Executive of Ireland v A Hospital Provider* [2023] EWCOP 55, the Vice-President, Theis J, rejected the proposition that there might be cases involving deprivation of liberty under cover of a foreign order put forward for recognition and enforcement which could be determined on the papers. The submission was made that the procedure could apply where:

> *(i) All parties, including the person who is the subject of the order, consent to the application;*
>
> *(ii) The person who is the subject of the order is already present in this jurisdiction and an order authorising the care arrangements for them has already been recognised and enforced by this Court; and*
>
> *(iii) The new order for which recognition and enforcement is sought involves no substantive change to the care arrangements for the person subject to the order, and merely extends the authorisation of those care arrangements under the inherent jurisdiction.*

However, Theis J continued:

> *23.* […] *as Mr Setright realistically recognises in his written submissions on this issue, there may be real limitations in such clear demarcation lines being drawn. It may be there are not extant and unequivocal written consents to the application, in which case an oral hearing will be required. Also, in circumstances where there is a time lapse between the order to be replaced and the fresh order this Court will still need to be satisfied that the relevant core criteria under Schedule 3 are established at the date of the making of the new Irish order, by reference to the supporting material, as well as considering whether any matters of public policy arise. Whilst a skeleton argument, cross*

> *referencing the supporting material to the core criteria may help, it may in reality reduce delay if this was undertaken at an oral hearing, even if a relatively short one.*
>
> *24. Finally, Mr Setright sets out, the inherent urgency of these cases often means they come before the court within 48 hours of the sealed Irish order becoming available. The transcript of the judgment sometimes comes later and the consents even later. In this case, the final order of the Irish High Court was provided on 16 October 2023 and this hearing took place two days later on 18 October 2023. This had consequent delays in the preparation of the bundle, which was not available until 11am the day before the hearing.*
>
> *25. Now having had the opportunity to consider the further written submissions from Mr Setright, I do not consider there should be any change in the arrangements for considering these applications. In accordance with paragraph 17 of Practice Direction 23A the presumption is that these applications will be determined at an oral hearing if they involve authorising deprivation of liberty. There should always be a skeleton argument filed in support, that takes the court through the relevant criteria and directs the court to how the criteria are satisfied by the supporting material lodged. There remains the option for this Court to consider whether a hearing is necessary but due to the urgency with which these applications have to be dealt with and the inherent lateness of all the supporting material being available there are only likely to be limited circumstances when such a course is appropriate, even when, at the very least, the requirements outlined in paragraph 22 above are met. I agree with the observations made by Mostyn J in Re SV that due to the seriousness of the consequences of the reciprocal order being sought, as well as the international aspects, such orders should only be made by a Court of Protection Tier 3 judge following an attended hearing in court, unless the Tier 3 judge otherwise directs.*

Theis J also set out observations as to the material that should be filed in support of a Schedule 3 application, and agreed that there should be a core bundle filed which contains the relevant documents in support of the application.

> *27. The core bundle should contain the following: (i) the application; (ii) the skeleton argument; (iii) the draft order; (iv) the consents (if applicable); (v) the order of the Irish High Court; (vi) the transcript of the judgment and, in cases where this is necessary, the transcript of the hearing. This is to cover situations, such as here, where the ex-tempore judgment refers to exchanges during the hearing. Where the transcript is lengthy relevant passages should be marked up and linked to the skeleton argument.*
>
> *28. In addition to the core bundle, there should be a separate bundle which includes the other relevant material from the proceedings in Ireland, so they can be referred to if required.*
>
> *29. It is hoped this structure will enable these applications to be determined with minimum delay and enable this Court to ensure that is it satisfied that the criteria under Schedule 3 MCA are met, including consideration of matters of public policy, and recognising the inherent seriousness of the relief sought, namely the making of summary orders for detention and treatment, albeit the original order is made in another jurisdiction.*

Fees consultation

The MOJ are consulting on increases to court fees, including those contained in the Court of Protection Fees Order (SI 2007 / 1745). The proposals would be to increase an application fee by £37 to £408; to

increase the appeal fee by £23 to £257; and to increase the hearing fee by £49 to £543. The Civil Proceedings Fees Order (SI 2008/1053) would also be amended in material part to increase the fee on the filing of a request for detailed assessment of Court of Protection costs by £9 to £96; to increase the to appeal against a Court of Protection costs assessment decision by £7 to £77; and to increase the fee payable when making a request to set aside a default Court of Protection costs certificate by £7 to £72. The consultation runs until 22 December 2023.

Short note: manipulative litigation tactics in the medical treatment context

We reproduce without editorial comment – save to note that they apply equally in the Court of Protection – the observations of the Court of Appeal at the conclusion of the Indi Gregory case:

> *Before leaving this matter, I would add the following. Although this is a legal decision, it is taken with a full awareness of the deeply sensitive question that lies at the heart of the proceedings. Indi's Guardian, who firmly opposes this application because of the continuing distress to Indi caused by the delays, rightly acknowledges that her parents love her fiercely and that it is impossible for us to fully comprehend their current circumstances. Nevertheless, I wish to express my profound concern about the approach that has developed in this litigation. The judge has throughout approached the assessment of Indi's welfare in a fair and sensible way and has reached decisions, of which the latest is but one, that were based on strong evidence that had been carefully tested. In the 25 days since his decision of October, a period during which good arrangements could have been made for Indi's benefit, there have been no fewer than six court hearings, each of them requiring very significant preparation and distraction of attention from Indi herself. As Ms Sutton says, a fair hearing has to be fair to everyone, and I would add, most of all to Indi. The increasing demands and changing positions of the parents have been extremely challenging for the clinicians, who have not only to look after Indi but twelve other critically ill children on the ward. The highest professional standards are rightly expected of lawyers practising in this extremely sensitive area. The court will not tolerate manipulative litigation tactics designed to frustrate orders that have been made after anxious consideration in the interests of children, interests that are always central to these grave decisions.*

THE WIDER CONTEXT

Care homes, hospitals and hospice visiting consultation response

As we went to press, DHSC published the responses to the consultation on visiting in these places, the summary being as follows:

> *The majority of responses supported the government's proposal to introduce a fundamental standard on visiting.*
>
> *The government will now work with CQC to develop and introduce a new fundamental standard. This will focus on visiting, against which CQC will assess certain registered settings as part of its existing inspection framework. We intend to lay the necessary regulations in Parliament to introduce this additional standard as soon as possible. We will also work with CQC to publish the necessary guidance to the health and social care sector to ensure this new standard is clear and upheld.*
>
> *Through this new standard, CQC will be able to specifically include visiting considerations as part of its wider regulatory assessment of providers. This could include using civil enforcement powers in line with its published enforcement policy when it is necessary and proportionate to do so.*
>
> *Of the themes we observed within our consultation, respondents cited that they found government guidance unclear, and that strict visiting times and complicated complaints processes were some of the barriers to visiting in health and care settings. Legislation will therefore help to create a consistent understanding of what is acceptable across all relevant providers. We will also seek to make guidance on the complaints process clearer for when issues do arise.*
>
> *Some respondents expressed concern that through the provision of a standard and accompanying guidance, 'exceptional circumstances' or 'reasonable explanations' (where a provider may restrict visiting) may actually provide the conditions for more restrictive practices, which is contrary to our intention. We recognise that there will always be some, very limited, circumstances in which visiting cannot be facilitated by the provider to maintain the safety and wellbeing of service users and staff. However, we do not plan to include a list of these circumstances in the statutory instrument itself. We are clear that visiting is critical to the health and wellbeing of everyone.*
>
> *While the majority expressed clear support for a consistent approach across CQC-registered settings, we recognise concerns raised by sector representatives about the requirements for some health and care settings potentially putting individuals at increased risk. For this reason, we intend to exclude services for substance misuse and inpatient detoxification or rehabilitation services from the requirement. This reflects the complex circumstances and risk of relapse for a vulnerable person, and visiting is already carefully considered within care plans in these settings. Supported living settings and 'extra care' housing schemes will also not be in scope of the regulation. These settings generally exercise 'exclusive possession', in which the individual has a tenancy agreement and they can decide who visits. All guidance will clearly set out the scope of this new regulation.*
>
> *We intend to address concerns about residents of care homes being discouraged to take visits out of the home by overly burdensome restrictions upon their return. A care home is a person's home, and we will be including a provision in regulations that residents should be encouraged to take visits out of the care home to support their wellbeing.*

We have received clear support and heard the positive impact that this policy would have, particularly for service users and their loved ones, with powerful personal testimony. The range of support provided by many visitors, which often extends beyond companionship to a 'care supporter' role and advocate, is fundamental.

Some have called for this right to be protected within new, primary legislation. Given the overwhelming support in this consultation, and the role of CQC as the regulator in England, the government believes the most proportionate and appropriate way in which to protect and enable visiting is to now move to introduce a new CQC fundamental standard on visiting. This puts visiting on the same level as other fundamental standards, such as that which requires providers to meet the nutritional and hydration needs of service users.

A new fundamental standard on visiting provides a standard to be enforced by CQC as part of its existing civil enforcement powers. This will highlight the importance of visiting to providers and all stakeholders, and ensure that providers account for the vital role that visiting plays.

One part did rather leap out as us – the assertion that those in supported living settings and extra care housing schemes generally exercise 'exclusive possession,' and in which the individual has a tenancy agreement and they can decide who visits. As a bald proposition this is distinctly questionable, and we might suggest not obviously a very sound foundation upon which to exclude those in such placements from the regulation – many of whom may very well be in places which could well change (in effect) overnight from a care home to a supported living placement without any actual change for the individuals concerned.

Forgetting to think and paying the cost

In the Local Government and Social Care Ombudsman complaint determination 22 017 529, the Ombudsman identified that North Yorkshire Council repeatedly missed opportunities to assess the mental capacity of a woman, Mrs Z, regarding her ability to manage her finances when this was in doubt. As a result, its decision to charge her for the full cost of her care fees for several years before she died, based on incomplete information regarding her finances, was fault. This fault caused significant uncertainty and distress to her relative, Mr X, who is the executor of her will. The Ombudmsan also found that he Council's communication and complaint handling with Mr X had also been poor. In recognition of the uncertainty caused by the Council's inadequate assessments of Mrs Z's finances, the Council agreed to write off the £21,987.06 debt it said she owed. The Council also agreed to apologise to Mr X, pay him £350 to recognise his own frustration and time and trouble and carry out several service improvements to prevent this fault occurring in future.

The decision stands as a helpful reminder that (as the Ombudsman says at paragraph 21) of the report "The [relevant person or body] must assess someone's ability to make a decision when that person's capacity is in doubt."

Short note: the cost of getting it wrong as a litigation friend

In the financial remedies proceedings in *Y v Z* [2023] EWFC 205, the litigation friend for the wife apparently became unwell, and essentially failed to do anything very much at all in his role as litigation friend. This led to a hearing where HHJ Edward Hess found himself in significant difficulties as regards

the way forward given the litigation friend's non-appearance and non-engagement. Whilst the judge managed to find a way through, the hearing could not be the final hearing that was envisaged, at a cost to the husband of some £42,128.79. The question was whether the costs should be borne by the wife herself, or by the litigation friend, Dr X. HHJ Hess concluded that it should be Dr X:

> *34. In deciding what costs orders to make I remind myself that the starting point (under FPR 2010 Rule 28.3(5)) is for there to be no order as to costs, but Rule 28.3(7) allows me to depart from this in certain circumstances, including where there has been relevant non-compliance with orders or litigation conduct (as there has been here, as described above). The Court of Appeal decision in Barker v Confiance Limited [2021] 1 WLR 231 suggests that, whether pursuant to the undertaking or by reference to Senior Courts Act 1981, section 51, the court can make a costs order against a litigation friend if, in all the circumstances, it is just to make a costs order.*
>
> *35. I have reached a clear view that the fair and just outcome here is for me to make an order for Dr X to pay the whole of the costs wasted by the hearing this week not being able to be dealt with as a full final hearing and I assess this at £42,128.79, to be paid within 14 days. While Ms Phipps invited me to consider apportioning this 50:50 between the wife and Dr X, I have decided that the appropriate order is to hold Dr X 100% responsible for these costs. He willingly took on the role of litigation friend and his performance has been wholly inadequate. I accept that he has not been well, but this fact does not adequately excuse or explain his conduct and he should not escape the consequences of what has happened.*

Tier 4 CAMHS, detainability under the MHA 1983 and (righteous) judicial frustration

Lancashire County Council v X [2023] EWHC 2667 (Fam) (High Court (Family Division) (HHJ Burrows)

Article 5 ECHR – deprivation of liberty – children and young persons

Summary

This case was rightly described by the judge as extremely disturbing, involving the most intense level of restrictions imposed on a child (of 15) seen by any of the professionals involved, but no obviously lesser state of restrictions that could be envisaged to keep her safe. The case had involved an escalating series of crises and stays in acute hospitals whilst a search for appropriate accommodation in the community continued. To give a flavour of the seriousness of the situation, we set out the narrative given by the judge in the lead-up to the most recent hearing.

> *26. At* [the earlier] *hearing, in agreement with Ms Bowcock, K.C., I said that this was clearly a case for a secure accommodation order. In fact, a secure accommodation placement might well be better for Claire because the relational security might be less intense. It must be difficult for somebody who is in good mental health to have four people with them all the time, but for somebody with the terrible difficulties that Claire has it must be awful. However, what else can be done when a person is trying to harm themselves as determinedly and seriously as Claire is? The most recent example I was given at that hearing was that she smashed a door down at the placement in the West Midlands, not so she could escape but so she could get access to the screws which she could then ingest.*
>
> *27. Before the hearing on 26 September there was another event where over the weekend Claire climbed on to a conservatory roof, smashed some glass and ingested it. As a result, she was taken*

to the A & E department at a Midlands Hospital, and as a result of that Carolann House gave immediate notice and they have refused to allow her to return, although they have continued to provide support for her in the Hospital. She remained in hospital in a cubicle off the ward, medically fit for discharge, where "medically" once again refers to physically fit, but there must be severe doubts as to whether she is mentally fit for discharge from a hospital.

28. However, once again she was assessed for MHA admission and the assessment proved negative. She is not in need of in-patient psychiatric care at Tier 4, it is said. So, LCC once again was left holding Claire in circumstances where, and this is not a criticism of the Council, they have no idea what to do with her. The only thing they can do is to look for a placement that may be able to provide her with support and care and then, once she is there surround her with what is assessed as being a necessary level of support in the circumstances.

29. If it is the wrong sort of place, a place that is not secure enough, then that level of security is going to have to be intense. It is probably going to be 4-to-1. That is likely to make things worse because Claire will see herself as being heavily restricted, and not having a normal life. Her ability to regulate the emotions that will follow from that are well-documented and non-existent. So, we can anticipate further self-harm, further destruction, further attempts to escape and further admissions to hospital if she is lucky enough not to kill herself in the process.

30. On 26 September 2023, the application before me was a modest one. Keep the restrictions in place but just change the address from the placement in the West Midlands to the cubicle off the Accident & Emergency Department at the Midlands Hospital where there will be four people constantly with her, constantly restricting her, occasionally restraining her, and always making sure that she does not harm herself.

As HHJ Burrows noted:

31. I found myself in a position where I had to authorise that level of detention because the alternative was too horrible to contemplate. However, I wanted to know why it is that CAMHS and Tier 4 psychiatric services consistently and persistently regard Claire as not being detainable under the MHA. She has a mental disorder. It appears it is of a nature and a degree that needs treatment of some sort and in a place of security. It means that she is an enormous risk to her own health and safety but also, potentially anyway, to others. In the absence of any other suitable placement, it seems necessary for her to receive at very least assessment and probably further treatment in a psychiatric facility to address that disorder. I am only a judge, I am not a psychiatrist or an AMHP, but Claire seemed to me to be detainable.

32. I wanted the person who most recently assessed her to provide the assessment and an explanation as to why, in their view, she is not detainable. The alternative to her being in a psychiatric facility is that she is in a non-psychiatric secure facility, potentially, or worse, in a wholly inadequate facility in which people are doing their best but are doomed to fail because of her behaviour. That is an explanation I wanted by the time of the next hearing.

At that hearing, HHJ Burrows:

33. [..] heard from a very senior and specialist nurse, HZ, who provided me with a statement and attended remotely to assist the Court. I am grateful to HZ for her expertise and candour. HZ explained to me why Claire was not detainable within a Tier 4 CAMHS facility under the MHA. That conclusion was reached after a lengthy period of assessment during which Claire engaged with

> *those assessing her. The assessors were aware of the detailed history I have summarised above. They were also aware of the CAMHS assessment carried out whilst Claire was placed in Salford. Claire's presentation in Salford was summarised in a letter from Greater Manchester NHS Foundation Trust dated 18 August 2023. During the assessment at Salford "there was no evidence of an acute mental disorder that would likely respond to treatment in an acute mental health inpatient setting. There was no objective evidence of mood disorder, acute anxiety or psychotic features". The self-harm Claire had inflicted "was in the context of emotional dysregulation linked to social stressors, namely……attachment difficulties and feelings of destabilisation due to multiple placement moves, and removal from family and usual social support networks".*
>
> *34. That assessment appears to focus heavily on the degree of disorder at the time of assessment and not on its nature over time. In relation to her family and usual support networks, it will also be noted that Claire's removal from her family and those networks came about because of the crisis I have described in which her family and those networks were incapable of keeping her safe. In short, I did not find the Salford assessment very compelling. HZ and her colleagues concluded that there were no obvious signs of a diagnosable mental health condition that would warrant Tier 4 admission. Her behaviour appeared to be "due to her traumatic and adverse childhood experiences" and (emphasis added) "she would warrant **longer term therapeutic work** in collaboration **with a contained and varying environment**".*

HHJ Burrows found himself:

> *36.* […] *extremely concerned about HZ's evidence and the position of her Trust. The apparent consensus amongst the mental health professionals who have treated Claire is that she needs treatment for her underlying disorder, but that is best achieved in a social setting which is stable, safe and secure. Until that is available the treatment will not be offered. This position appears to ignore what is almost universally recognised elsewhere, namely that there is a chronic lack of secure accommodation for our young people with serious mental health and behavioural problems. I need only refer to the recent judgment of the President, Sir Andrew McFarlane in Re X (Secure Accommodation: Lack of Provision) [2022] EWHC 129, along with his predecessor six years ago, in Re X (A Child) (No. 3) [2017] EWHC 2036 (per Sir James Munby, P) to provide support for this Court's concerns. Furthermore, in the Court of Protection recently, Theis, J, VP, made the same point in an appeal from one of my decisions concerning the lack of appropriate accommodation for challenged young people: see Manchester University Hospitals NHS Foundation Trust v JS (Schedule 1A Mental Capacity Act 2005) [2023] EWCOP 33.*

HHJ Burrows heard from the consultant within the Sandwell CAMHS crisis team, who was able to offer that DBT treatment could start immediately, which "*recognises two aspects of this case that seem clear. First, that Claire needs therapeutic input to address the underlying mental health condition, whatever that may be. Although she ideally needs that in a place where she is secure and stable, the fact is that level of security and stability simply is not available at the moment. Finding an alternative placement is likely to prove difficult and may involve a protracted search period, and that is the second aspect. Certainly, if the experience of previous searches is an indicator, finding a satisfactory placement rather than one that is barely adequate will take a while. In the meantime, Claire needs the treatment and other input*."

However, pending the identification of appropriate secure accommodation, and

> *45. So far as the Tier 4 issue is concerned, I remain troubled that this young woman who has been dysregulated for so long and has been so determined to cause herself serious harm, is not*

> *detainable under the MHA. However, there is nothing this Court can do to require the use of the MHA. The guardian is pondering whether judicial review of the sectioning decision is a feasible option. I consider in the meantime that it is necessary for an expert to be instructed to consider Claire's overall mental health care and the direction of that care. This appears not to be taking place in a coordinated way as it is. What I cannot do is compel anyone to detain Claire under the MHA. This was made clear, albeit under slightly different circumstances by Mr Justice McDonald in Blackpool BC v HT (etc) [2022] EWHC 1480. What His Lordship said at [51] is also highly relevant to this case:*
>
>> *This matter represents another example, amongst many examples, of a case in which the acute lack of appropriate resources, for children assessed as not meeting the relevant criteria for detention under ss 2 or 3 of the Mental Health Act 1983 (the 1983 Act) but requiring therapeutic care within a restrictive environment for acute behavioural and emotional issues arising from past trauma, creates tension between a local authorities and the NHS. As a result, the matter comes before the court with the local authority asserting that the NHS should be making provision for the child and the NHS arguing that the child does not meet the criteria for such provision.*
>
> *46. I am troubled however, that those involved in CAMHS provision and Tier 4 decision making have to recognise this resource crisis and have to take the lack of adequate social provision into account when making decisions under the MHA. Of course, a 14- or 15-year-old child should not be detained in a secure psychiatric facility if there is a less restrictive option that can achieve appropriate care for her. Or, put another way, treatment in Hospital is not necessary if (but only if) there is suitable care available outside Hospital. If that placement is not available within a reasonable timescale, then treatment in Hospital is surely necessary. I have dealt with this elsewhere, in a similar context, in Manchester University Hospitals v JS [2023] EWCOP 12.*

HHJ Burrows found himself able to authorise the continued deprivation of Claire's liberty where she was given that she was slightly better settled, and declaring that it was in her best interests to receive such treatment.

Comment

Grimly, Claire's situation is, as HHJ Burrows identified, not unusual, as systems essentially continue to be pushed to and beyond their limits in the face of increasing demand (especially amongst adolescents) and diminishing supply. HHJ Burrows' concern about the approach of those charged with Tier 4 assessment has been shared by other judges, and indeed, more broadly by those who are troubled about the fact that what is in effect a commissioning process appears to drive consideration of whether a person is or not detainable under the MHA 1983, a question which is not on its face anything to do with resources.

It is striking in this case that a judicial review was being contemplated to tease out the question of why Claire was not considered detainable for purposes of the MHA 1983. However, it is also necessary to highlight that HHJ Burrows' approach to detainability might need something of a recast in light of the decision of the Upper Tribunal in *SF v Avon and Wiltshire Mental Health Partnership* [2023] UKUT 205 (AAC), a decision which may suggest that a rebalancing towards greater recourse to judicial authorisation (for those under 18) and /or recourse to DoLS (for those over 18 lacking the relevant decision-making capacity) for those cases where, in effect, all that is being done is keeping the person

as physically safe as possible.

Wales striking out alone on mental health reform?

In a fascinating development, James Evans MS, who won the relevant ballot, is to seek to put before the Senedd in Wales the equivalent of a Private Members Bill to amend the provisions of the Mental Health Act 1983 so as to introduce significant parts of the reforms proposed by the Independent Review of the Mental Health Act. The proposals have the support of Mind Cymru; Adferiad; the Royal College of Psychiatrists; and the Royal College Mental Health Expert Advisory Group.

The Explanatory Memorandum to the proposal for a Mental Health Standards of Care (Wales) Bill explains how the Bill would:

1. Enshrine statutory principles on the face of the MHA 1983 in Wales;
2. Replace the Nearest Relative (NR) provisions in the Act with a new role of Nominated Person; and
3. Enshrine a change in the criteria for detention to ensure that people can only be detained if they pose a risk of serious harm either to themselves or to others, and that there must be a reasonable prospect of therapeutic benefit to the patient.

A further change – not proposed by the independent Review – would be to introduce the provision for remote (virtual) assessment under 'specific provisions' relating to Second Opinion Appointed Doctors (SOADs), and Independent Mental Health Advocates (IMHAs). And further changes would be introduced to the existing Mental Health (Wales) Measure 2010 to ensure that there is no age limit upon those who can request a re-assessment of their mental health and to extend the ability to request a reassessment to people specified by the patient.

The Explanatory Memorandum sets out a number of areas that were considered, but not advanced, as follows:

> a. *Placing a duty on clinicians to have regard to advance choices – the clinical checklist provisions. This is largely a codification of what should already be happening, and as a matter of good clinical practice could be progressed without legislation.*
>
> b. *Shortening the period that a patient may be kept in detention for treatment so that a patient's initial detention period will expire sooner and if the patient's detention is to continue it must be reviewed and renewed more frequently. There are some resource implications to this in terms of clinician and others time to carry out the reviews more frequently.*
>
> c. *Amending the frequency that a person may seek reviews through Mental Health Review Tribunals (MHRTW). This would result in a different regime compared to England and would have significant resource implications as the MHRTW would need greater capacity to deliver this.*
>
> d. *Amending section 132 of the Act to place a statutory duty on hospital managers in respect of detained patients to supply complaints information to both the patient and the NP. Supply of information could be achieved without legislation. From April 2023 there is a legal duty of candour requiring NHS organisations in Wales to be open and transparent with service users,*

which includes talking to service users about incidents that have caused harm and apologising and supporting them through the process of investigating the incident.

e. *Amending s.117 aftercare provisions to ensure the deeming provisions are consistent with other legislation. This relates to who is responsible for providing aftercare when a patient moves between different local authority areas. This has been a more significant issue in England than in Wales. Since we cannot legislate to change the system in England, Wales-only legislation would only serve to complicate matters around crossborder issues, and risks potentially creating cracks in the system.*

f. *Autism and learning disabilities. Changing in how the Act applies to patients with a learning disability and/or autistic people under Part 2 of the Act to end the practice of patients in this group being detained under the Act in unsuitable long-stay wards, in line with the principle of least restriction. Welsh Government are currently reviewing the Code of Practice for Autism Services. How neurodivergent people including autistic people receive support / treatment when diagnosed with co-occurring mental health concerns will be integral to this review*

It is perhaps of note that the proposed measure draws directly on the work of the Independent Review, rather than on the draft Bill put before the Westminster Parliament and, as such, for instance, proceeds on the basis that it is possible to put principles on the face of the MHA 1983. It is also of note that the measure does not seek to remove autism and learning disability – a proposal that had been put forward in the draft Bill, but which the Independent Review had not called for as it did not consider that such would solve the problem of unnecessary and unnecessarily extended detentions of autistic people and those with learning disability.

Assuming that this progresses, this is a striking development by contrast to the legislative silence that has descended in England. It also raises the prospect of some interesting devolution issues to navigate as regards (for instance) the application of the statutory principles to Part 3 patients.

For those wondering whether an enterprising MS might take the opportunity of introducing an equivalent provision to bring into force the LPS or an equivalent thereof in Wales, the answer is such lies outside the legislative competence of the Senedd (otherwise, given the furious response of Welsh Government to the delay, it is entirely likely that it would have sought to do itself).

The Health and Social Care Committee sounds concerns about Right Care, Right Person

The Health and Social Care Committee sent a letter in September (the precise date does not appear on the letter) to (then) Secretary for Health and Social Care Steve Barclay setting out a number of concerns about the Right Care, Right Person National Partnership Agreement ('RCRP'). This followed an evidence session held in September 2023. The RCRP approach was first developed in Humberside, and has now been made the subject of an agreement between DHSC, the Home Office, NHS England, the National Police Chiefs' Council, the Association of Police and Crime Commissioners and the College of Policing on what steps should be taken around individuals experiencing mental health crises.

The Health and Social Care Committee heard from police and health representatives from Humberside and the West Midlands, where the approach is being rolled out, as well as from the charity Mind. The committee expressed its concerns that RCRP cannot work without health partners responding in a

timely manner. However, it appeared that police forces were proceeding with withdrawing support regardless of whether health systems were ready to take on a more prominent role. Evidence from the West Midlands was that the mental health trust was looking to implement RCRP within a 12-18-month timeline. It was not apparent what financial support was being provided by NHS England to support trusts and ICBs, whether this would represent additional funding, or whether ICBs and Trusts would be required to take up new duties out of existing budgets. A recommendation was made that clarity be provided in the Autumn Statement.

The Committee highlighted that while representations had been made about how much police time and resources would be saved, there appeared 'to be a total lack of evaluation in terms of health outcomes or services.' There had been no real evaluation on the effects on health services in Humberside, and the Committee was keen that this not recur in the national rollout. The Committee recommend that health evaluations are set up in all areas that implement RCRP, designed and implemented with national support.

The Committee also noted that while it supported reducing waiting times in A&E, a 'move towards a one-hour handover as "a very difficult ask for the NHS" giving the example of 11-hour waits in the West Midlands.' In Humberside, a real challenge was that there were not sufficient psychiatric inpatient bed to facilitate patients moving on from A&E. This challenge was not unique to Humberside, and the Committee felt it "*is important therefore that NHS England works to provide a solution to the challenges in A&E*." It recommended that:

> *the Government and NHS England explore, through consultation, options to speed up the assessment process and ensure a timely handover of care from police officers to the healthcare service. These options might include steps to ensure that sufficient staff are available 24/7 to complete mental health assessments for patients in A&E, designating A&E as a place of safety, strengthening the Mental Health Act Code of Practice or funding to build dedicated areas in emergency departments to support those with mental health needs who also have a physical injury. The rollout of mental health liaison services in acute hospital emergency departments provides a good opportunity to address the challenges we have heard in terms of staffing. The reform of the Mental Health Act and the New Hospitals Programme also present opportunities to address this* […] *.but there are issues that must be addressed to ensure a consistent, safe and well-monitored rollout.'*

My heart breaks – solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people

Baroness Sheila Hollins has published her final report as Chairperson of the Independent Care (Education) and Treatment Review (IC(E)TR) programme for people with a learning disability and autistic people in inpatient settings. In fact the final report was completed in July 2023, but was not published until 8 November 2023, alongside the Government's responses. The summary of the report, entitled *My heart breaks – solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people*, is as follows:

> *This report focuses on people with a learning disability and/or autistic people who are detained in mental health and specialist learning disability hospitals.*

> *The Independent Care (Education) and Treatment Review (IC(E)TR) programme reviewed the care and treatment of 191 people who were detained in long-term segregation between November 2019 and March 2023. The programme was established because of serious concerns about the use of long-term segregation, and in particular about lengthy stays and difficulties in discharging people from long-term segregation. The aim was to identify the blocks to discharge and to assess whether independently chaired Care (Education) and Treatment Reviews (C(E)TRs) would be more effective than commissioner chaired C(E)TRs in developing the right support for each person detained in long-term segregation.*
>
> *Safe and wellbeing reviews set up after the Cawston Park Hospital Inquiry assisted in identifying people in long-term segregation. At the start of the second phase of the programme there were 115 people in long-term segregation and a similar number were in long-term segregation at the end. At the time of writing, of the 114 people who received an IC(E)TR in the second phase, 48 had moved out of long-term segregation, including 7 people who had been discharged from hospital.*
>
> *The data collected by NHS England does not measure the numbers of people who have had an IC(E)TR, remain in hospital and have been moved to conditions of higher security. Robust information is also not available about whether any of the 191 people who received an IC(E)TR review have since died, due to inconsistencies in reporting by providers. This information is critically important and should be considered by NHS England and the Care Quality Commission (CQC) for future work in this area. I am pleased to hear that CQC are beginning to address this through improvements to their notifications system.*
>
> *During this period some additional interventions were established in an attempt to improve individual outcomes. A Senior Intervenors pilot which supported 17 people (but ended in March 2023 pending evaluation of its effectiveness), and the HOPE(S) practice leadership and culture change programme (funded until 2024) were both commissioned by NHS England. These interventions, working alongside IC(E)TRs, have helped to achieve the outcomes obtained so far.*
>
> *The Oversight Panel found a lack of urgency in addressing the many systemic issues that were identified through the IC(E)TR reviews.*
>
> *International consensus across various sectors and disciplines on the harms caused by enforced isolation are scientifically evidenced and compelling, and the consensus is that enforced isolation has no therapeutic benefit.*
>
> *Members are unanimous in recommending that all instances of enforced social isolation, including seclusion and long-term segregation, should be renamed 'solitary confinement'. The panel recommends that its use with children and young people under the age of 18 should be ended with immediate effect, and that the use of solitary confinement for people with a learning disability and/or autistic people should be severely curtailed and time limited. Minimum standards for the use of solitary confinement should be introduced urgently through amendments to the Mental Health Act 1983: Code of Practice.*

The DHSC's responses to the unanimous recommendations can be found here.

WHO / OHCHR guidance on mental health, human rights and legislation

The World Health Organisation and the Office of the High Commission on Human Rights have jointly

launched new guidance entitled “Mental health, human rights and legislation: guidance and practice.’ The guidance proposes new objectives for law, including setting a clear mandate for mental health systems to adopt a rights-based approach. It outlines legal provisions required to promote deinstitutionalisation and access to good quality, person-centred community mental health services. It highlights how laws can address stigma and discrimination and provides concrete measures on how to eliminate coercion in mental health services in favour of practices that respect people’s rights and dignity.

There is much very useful material in the guidance about practical steps that can be taken to reduce coercion. However, as the guidance notes (at page 12):

> *The adoption of the CRPD has prompted new commitment in reforming legislation on mental health. While it is too early to understand the true impact of the CRPD on national mental health legislative frameworks, as discussed in Chapter 2, several countries have begun to integrate CRPD-inspired measures into their laws, such as reasonable accommodation, advance directives, and supported decision-making. Nevertheless, most countries have fallen short of challenging biomedical approaches and the legitimacy of the denial of legal capacity and compulsory treatment powers, thus failing to embrace rights in the field.*

An alternative framing of this might be that most countries have adopted what the CRPD requires, rather than what it is said to require by the CRPD Committee. And, again, it would be immensely helpful if the WHO / OHCHR could clarify whether they consider that the same approaches apply outside the response to mental ill-health, for instance to dementia, acquired brain injury or intellectual disability.

Book Review

Arianna Kelly, *Social Care Charging* (Law Society, 2023, 368 pages, £75)

In the pithily titled “Social Care Charging” Arianna Kelly has provided a practical guide for practitioners picking their way through the minefield of charging for care under the Care 2014, and navigating questions of capital, disregards, direct payments and top ups.

Over eleven clearly set out and well-signposted chapters, Kelly’s book takes the reader through the legislative context and the practical implications of each aspect of the social charging framework. This includes analysis of the inevitable interplay between the Mental Capacity Act and the various charging regimes, and the obligations on local authorities – and other relevant parties – to consider P’s capacity to consent to arrangements or the steps that must be taken to provide assistance to those lacking capacity with regard to property and affairs who are in need of statutory funding or otherwise fall to be financially assessed and evaluated.

Kelly ventures beyond the usual statute-case law confines of such textbooks. This book includes extracts of contemporary legal reporting that informs practitioner debates in order to answer the sorts of questions with which lawyers commonly and currently struggle. The book also contains the relevant extracts of a wide range of underpinning statutes and statutory instruments, extending as far – helpfully – as to include specific extracts of the Mental Health Act 1983.

As she tells us, Kelly herself worked on the draft Care and Support Bill and the depth of her knowledge

of some issues – and her frank acceptance that some questions and issues (such as the complexity of paragraph 15 of Schedule 1 of the Care and Support (Charging and Assessment of Resources) Regulations 2014) are as yet without an answer and in need of further judicial consideration – is clear and refreshing. The book professes its aim as providing *"an accessible, practical guide to answering common issues about adult social care charging and financial issues"*. In my view, it succeeds wholeheartedly in this endeavour, not least in its provision of what I consider to be the key to any effective practitioner textbook: a thorough and workable index. Highly recommended.

Nicola Kohn

IRELAND

Introduction

Following on from our analysis of the Codes of Practice in the October 2023 newsletter, we will discuss the Code of Practice for Financial Advisors and the impact of the ADCMA 2015 on the regulatory framework for the financial services industry in Ireland.

It is interesting to note, that a documentary by the national Broadcaster RTE in 2021 on the Wardship regime[3], raised many questions as to how the new Assisted Decision-Making regime would adapt and develop, regarding the assistance and support of the relevant persons with their financial affairs.

DSS Code of Practice for Financial advisors

The DSS Code of Practice gives a plain English approach to the considerations a financial advisor will need to reflect upon when providing these supports to the relevant person.

Some of these considerations include:

- the type of decision to be made;
- the complexity of the decision to be made;
- the person's individual circumstances;
- when the decision has to be made.[4]

The Code also underlines the responsibilities of financial advisors and reminds them that their previsions of the code do not alter their existing obligations to advise.[5]

> *It is important to remember that the provisions of this code do not alter any existing obligations that apply to financial service providers under consumer protection codes. For example, in providing advice or a financial service, or selling a financial product, a financial service provider*

[3] RTE, "Wardship -The Decision Makers."
[4] DSS, "Code of Practice for Financial Service Providers" at pg. 6, available at link here.
[5] Central Bank of Ireland (Central Bank) regulates financial services providers in Ireland. See website here

may already need to consider whether a specific financial product or service is suitable for their customer.[6]

The Code also underlines that the varying complexity of financial decisions different financial products or services require varying levels of capacity.

Different financial products or services require different levels of capacity. For example, a relevant person may require no support in making decisions around their day-today banking but may need support to take out a loan in order to understand the repercussions of failing to make a repayment.[7]

Some of the considerations, for financial and banking service providers around the ADCMA 2015 act in the coming months and years will include the design of additional features and services, some of these may include:

- *Designing ADCMA 2015 compliant features and services applied at client on-boarding (e.g. taking out insurance or creating a new bank or savings account).*
- *Drafting and reviewing ADCMA 2015 compliant suites of support documents for staff who will be interacting with relevant persons, decision-making assistants or co-decision-makers on a regular basis.*
- *Have appropriate systems (online or in person) in place to support ease of use, case management etc. for relevant persons or their support tier, in respect of financial services.*
- *Financial Service providers will need to continue to create awareness around customer-facing staff in relation to identifying and dealing with capacity issues by supporting the decision-making process.*

Future Developments

It is also worthwhile noting that the implementation of the Assisted Decision-Making act 2015 has acted as an impetus for the review of the Consumer Protection Code[8], specifically in respect of 'vulnerable customers.

The Central Bank confirmed the importance that the new requirements are considered in the ongoing review of the Consumer Protection Code. Vulnerability is a specific topic in the Code Review as well as consumers' best interests.[9]

The Irish Banking Culture Board (an initiative funded by the 5 main retail banks within the Irish Market) made submissions to the Central Bank on this topic noting:

The Group may also support the Central Bank to enhance consumer protection, as the Consumer Protection Code is updated and other legislation, such as the Assisted Decision-Making Act (2015)

[6] DSS, "Code of Practice for Financial Service Providers" at pg. 10
[7] *Ibid.*
[8] Central Bank, "The Consumer Protection Code."
[9] Central Bank, "Consumer Advisory Group (CAG) Minutes of Meeting."

> *comes into force, which will result in additional codes of practice for finance professionals.*[10]

Conclusion

The review of the Consumer Protection code is timely considering the changing financial services landscape, the implementation of the ADCMA 2015 and the challenging circumstances facing many consumers, especially those who may be experiencing difficulties during the current cost of living crisis.

It will be interesting to see how the regulatory framework will be reviewed and amended to provide supports to vulnerable persons and to relevant persons under the ADCMA 2015.

Henry Minogue BL

[10] Central Bank, "Irish Banking Culture Board Submission to Central Bank of Ireland in response to Consultation Paper 136: Enhancing our Engagement with Stakeholders."

SCOTLAND

Reduction of a Will: incapacity and various vitiating factors

On 25th September 2023 Sheriff Christopher Dickson, sitting at Edinburgh Sheriff Court, addressed issues of retrospective assessment of alleged incapacity, facility and circumvention, and undue influence, in relation to a Will by Josephine Margaret Allan ("the deceased"), in *Graham Bruce Somerville v Alasdair Roderick Allan qua Executor-Nominate of the late Josephine Margaret Allan, and as an individual*, [2023] SC EDIN 38. The deceased was maternal aunt of the pursuer and sister of the defender. She had executed a Will on 27th November 2018 ("the 2018 Will") (which was not subject to challenge), followed by another Will on 11th August 2019 ("the 2019 Will") in radically different terms, which was the subject of challenge. She died on 28th September 2019, aged 74. Few readers will wish to read all 162 pages of Sheriff Dickson's Judgment and Note [66 paragraphs of the Judgment, followed by findings in fact and law, and findings in law, and 275 paragraphs of the Note] , so after (1) a brief outline of the factual background, I have picked out from the great wealth of content in the Judgment, some points of significant relevance to adult capacity law and practice, namely (2) the sheriff's findings in fact and law (in terms of his Judgment), (3) some interesting material narrating the task of medical practitioners, and their assessments, (4) the sheriff's method of assessment of evidence, that he applied to each witness, (5) the sheriff's views on the grounds of facility and circumvention, and undue influence, (6) the sheriff's findings on the effectiveness of a witness seeing a party sign but not seeing the content of the document; and two points of interest which it was not necessary for the sheriff to address, namely (7) error as a vitiating factor, and (8) comments on major current examination of "will" and conflicting expressions of "will".

(1) Summary

The 2018 Will was prepared on the deceased's instructions by solicitors ("the deceased's solicitors"). It appointed the pursuer as sole executor and bequeathed to him the residue, including the deceased's house, subject to the following legacies:

1. Two signet rings to Jennifer and Laura;
2. Car and Bose music centre to the defender;
3. Two horses, Dale and Missy, to Ian Butt;
4. Cat, Tiger, to Patricia; and
5. Any items within her property that Patricia, Jennifer and Laura wish to have.

Patricia was the sister of the defender and the mother of the pursuer, and of Jennifer and Laura. The deceased loved animals and owned two horses: Ian Butt was her favourite veterinarian.

The full terms of the 2019 Will are quoted at [41] of the Judgment. The 2019 Will was typed by the defender on his typewriter and witnessed by a friend of the defender. Under it the deceased appointed the defender to be sole executor, and provided that:

> *"I do solemly declare that in the event of my death, it is my express wish that all my worldly goods, house, possessions, property, animals & live-stock fall into the ownership & care of [the defender], with the provision that he oversees the safe transport of my horses, Dale and Missy, into the trusted care of Mr. Iain Butt, [address]."*

On 13th August 2019 the deceased saw Ms Lawrie of the deceased's solicitors and gave Ms Lawrie the new Will, with instructions that it superseded the 2018 Will. Ms Lawrie enquired why the deceased had changed her Will. The deceased gave an explanation which, as narrated below, was held by the sheriff to be factually incorrect. The deceased also instructed a power of attorney in favour of the defender.

The deceased died unmarried and without issue on 28th September 2019.

(2) The sheriff's findings in fact and law (in terms of his Judgment)

The following were the sheriff's findings in fact and law:

1. *That the terms of the 2019 will were unheralded.*
2. *That the deceased did not receive any independent advice or assistance before making the 2019 will.*
3. *That when making the 2019 will on 11 August 2019 the deceased: (i) understood that she was changing her will and making the defender her sole beneficiary; (ii) understood that all her belongings, including her house, would be going to the defender; and (iii) comprehended and appreciated that the pursuer and the rest of the Somerville family would have had an expectation of being beneficiaries under any will made by her.*
4. *That the deceased made the 2019 will on 11 August 2019 because of the following two reasons: (i) since the pursuer had found out that he was to benefit from everything in the 2018 will she had not seen him in over a year – he had not been at her house or anywhere near her; and (ii) the defender was now the person who was helping her out with everything due to her being very ill. Those two reasons were incorrect. Those two reasons influenced the deceased's will in disposing of her property and brought about a disposal in the 2019 will, which, if the deceased had been of sound mind, she would not have made.* [This is the finding on which I comment under heading 7 below.]
5. *That the deceased lacked testamentary capacity when she made the 2019 will and therefore the 2019 will should be reduced.*
6. *That upon the 2019 will being reduced the defender will have no title to intromit with the deceased's estate. The defender continues to have access to the deceased's house. In the circumstances when decree of reduction is granted, decree of interdict should also be granted to prevent the defender from intromitting with the estate of the deceased.*

(3) Some interesting material narrating the task of medical practitioners, and their assessments

The relevant medical history, including the history of assessments of capacity, is narrated in paragraphs [16] through to [25] of the Judgment. That passage reproduces several relevant medical notes. Further medical history, with reproduction of further medical notes, appears in paragraphs [51]

to [64] of the Judgment. All of this material is valuable in demonstrating the amount of care and skilled medical time devoted to the task of attempting to assess on an ongoing basis whether the deceased had capacity to make decisions in medical matters, or whether it would be appropriate to apply non-consensual procedures, in a case where the deceased for most of the time was hovering at the limits of competence for such matters. In these practical situations, notable is the extent to which efforts were made to afford maximum feasible respect to the deceased's expressed will and preferences by identifying and offering arrangements that could be followed with her consent, rather than applied under appropriate procedures without her consent. This approach was well encapsulated by Dr Lee, consultant geriatrician based in London. He had not seen the deceased. He expressed opinions drawn from the medical records and statements provided to him. As narrated at [76] in the Note:

> *"Dr Lee explained in practice medical professionals try and take the least restrictive option. The tendency is to try and facilitate the patient going home, particularly if the family agree with that decision. If going home then fails the medical professionals would try and negotiate another path and attempt to get the family on board with that. However, it would sometimes be necessary to use powers under the Mental Health Act to detain the patient if it was felt the patient did not have capacity."*

For clarity, it is worth repeating Dr Lee's explanation narrated at paragraph [71] of the Note:

> *"Dr Lee explained that it was possible for a person to have capacity for one thing and not another. It was also possible for a person to lack capacity but subsequently regain capacity, however, this depended on the cause of the lack of capacity. Where the patient suffered from a progressive condition, such as dementia, once capacity was lost the patient would not be expected to regain capacity."*

He emphasised more than once that capacity to decide to go home was not necessarily the same as testamentary capacity, testamentary capacity generally requiring a higher level of capability. Dr Lee also pointed out that the medical team treating the deceased were focused on questions of capacity to decide medical matters, and whether to return home.

At [260] of his Note, Sheriff Dickson agreed with the opinion expressed by Dr Lee that:

> *"The two reasons why the deceased changed her will [from the 2018 Will to the 2019 Will] could properly be described, for the purposes of stage 4 of the 4 stage test in the case of Banks [v Goodfellow (1870) LR 5 QB 549, [1861-73] All ER Rep 47], as delusions which influenced the disposing of the deceased's property and brought about a disposal of it which, if she had been of sound mind would not have been made. The two reasons were, in my opinion, to use the words of Viscount Haldane in Sivewright [v Sivewright's Trustees, 1920 SC (HL) 63] an actual and impelling influence on the deceased making the 2019 will. They resulted in the deceased making the 2019 will with terms that were contrary to the 2018 will and contrary to the testamentary intention the deceased: …"*

The 4 stage test in the English case of *Banks* was quoted with approval by Lord Atkinson in *Sivewright*. Sheriff Dickson held that the first three stages of the test had been met: the deceased understood the nature of the act and its effects; she understood the extent of the property of which she was disposing; and she was able to comprehend and appreciate the claims to which she ought to give effect. However,

he held that she failed the fourth test, that for the purpose of comprehending and appreciating the claims to which she ought to give effect, it was necessary –

> *"That no disorder of the mind shall poison [his] affections, pervert [his] sense of right, or prevent the exercise of [his] natural faculties – that no insane delusion shall influence [his] will in disposing of [his] property and bring about a disposal of it which, if the mind had been sound, would not have been made."*

(4) The sheriff's method of assessment of evidence, that he applied to each witness

The pursuer led evidence from several family members. Sheriff Dickson pointed out that they clearly supported the pursuer's case and could not be described as independent. There was also much evidence about events and conversations that could not be independently verified. At paragraph [226] of his Note he explained that:

> *"I sought to test the evidence of each witness by considering whether their evidence was internally consistent and by comparing and contrasting their evidence with other evidence I accepted, including the contemporaneous records that were available."*

Applying these tests, witness by witness, he concluded that each of the pursuer's family witnesses was credible.

(5) The sheriff's views on the grounds of facility and circumvention, and undue influence

As Sheriff Dickson had held that the deceased lacked testamentary capacity when she made the 2019 Will, it was not necessary for him to address the questions of facility and circumvention, and undue influence; but against the eventuality that he was wrong on the question of capacity he did comment on those.

On facility and circumvention, Sheriff Dickson concluded [264] that the deceased was generally strong-willed, but not when it came to the defender. She was scared of the defender and wanted the defender to move out of her house, but she did not like confrontation and, as a result, put up with him living there. If she did not lack testamentary capacity when making the 2019 Will, nevertheless "*her mind was so weak and pliable that she was unlikely to be able to resist pressure applied by the defender*". Lesion was clear from the fact that the defender was sole beneficiary under the 2019 Will, and the circumvention could be inferred from the whole circumstances, including in particular "*the problematic relationship that the deceased had with the defender*", and her recent expressions of her testamentary intentions which were contradicted by the terms of the 2019 Will. He concluded that if the deceased had had testamentary capacity on 11th August 2019, the sheriff would have found that the 2019 Will was voidable and ought to be reduced on the basis of facility and circumvention.

On undue influence, Sheriff Dickson considered [265] that the defender had a dominant or ascendant influence over the deceased. He himself prepared the 2019 Will, and arranged for the witness. Among other factors narrated by the sheriff were that the deceased "*allowed herself to be driven to Peebles for*

the appointment with Ms Lawrie on 13 August 2019 and wanted the defender to be appointed as her attorney". At the time, the deceased placed confidence and trust in the defender. The 2019 Will benefited him. The deceased did not obtain independent advice or assistance before the 2019 Will was made. Again, the sheriff referred to the problematic relationship between the deceased and the defender, and her recent expressions of testamentary intention. He considered that, if the deceased had had testamentary capacity, the whole circumstances of the case justified the inference being drawn that the defender had abused his relationship of trust with the deceased, and that the 2019 Will would have been voidable and ought to be reduced on the basis of undue influence on the part of the defender.

(6) The sheriff's findings on the effectiveness of a witness seeing a party sign but not seeing the content of the document

The content of the 2019 Will was not visible to Mr White when he witnessed the Will, because the content was covered by a sheet of paper. Sheriff Dickson dismissed that argument on the basis of the authorities that he cited in [272].

(7) Error as a vitiating factor?

"Error in substantials, whether in fact or in law, invalidates consent, or rather excludes real consent, where reliance is placed on the thing mistaken" (Bell, *Principles*, s11, 10th edition; Stair, I, 10, 13; Opinion of Lord Watson in *Stewart v Kennedy* (1890) 17 R. (HL) 25 at 26). That is the settled law in relation to contract. It is an exception to the general rule that a plea that a party to a contract would not have entered it if he had known all the relevant facts has been described as "so utterly preposterous as to be undeserving of any attention" (*Forth Marine Insurance Co. v Burnes* (1848) 10 D. 689, per Lord Fullerton). The exception, whether shared or unilateral, and whether induced or uninduced, renders a contract void, rather than voidable, but it must be an error as to the substantials of the contract.

But what about fundamental error, uninduced, in a unilateral document such as a Will or a power of attorney? Under heading (2) above, I have already indicated that item 4 of the sheriff's findings, quoted there, is potentially relevant to that question. It is not clear whether the deceased's erroneous belief described there was induced or uninduced, but let us assume that it was uninduced. Her error does seem to have been fundamental (an "error in substantials") because those are the reasons that she gave when asked why she had changed her Will. Again, let us here assume that if the point had been raised, that it could reasonably have been held that this error was substantial, and that but for that the deceased would not have changed her Will.

Sheriff Dickson dealt first with the assertion that the deceased lacked capacity to grant the Will because, if she did, that would render the Will void, and rendered it not only unnecessary but irrelevant to consider the grounds of possible voidability, namely facility and circumvention, and undue influence. If however a fundamental uninduced error had also rendered her Will void, then I would suggest that the sheriff could have decided the case on that basis alone, without several days of evidence addressing the question of her capacity. The Will would have been void, a nullity, of the same status as if it had never existed, likewise displacing the potential grounds of voidability.

I invite any reader to let me know if that reader has been able to identify any clear authority on whether

fundamental error, whether induced or uninduced, renders void a unilateral document such as a Will or power of attorney, in the same way that it renders void a bilateral obligation such as a contract. I would venture to suggest that on grounds of basic principle and logic, it must. A lack of any valid exercise of will in order to commit to a juridical act, whether in bilateral or unilateral context, must in both cases render the apparent act a nullity[11]. I suggest that it cannot do so in one of those situations, but not in the other.

During my practising career, I did advise another solicitor in a situation where that point could have been determined. An elderly lady had changed her Will to disinherit a relative who had been her main helper, guide and supporter for years. She depended upon him. She had to be admitted to a nursing home. She was unsettled and upset. She telephoned him. Her reason for changing her Will was that she was so appalled that in her time of greatest need, the person upon whom she so greatly depended, and in whom she had so often placed her trust, had hung up on her. In reality, she was unused to using a payphone, and her money had run out. Sensibly, though unhelpfully for the development of Scots law, the various parties having an interest agreed a solution, once it had been explained to those benefiting from the change that I was prepared to run an argument that in the circumstances the Will was void (with prospects of "winner takes all", but deduction from "all" of substantial costs, potentially including those of an appeal and even a further appeal).

(8) Comments on major current examination of "will" and conflicting expressions of "will"

The concept of "will" is fundamental to interpretation and application of the UN Convention on the Rights of Persons with Disabilities ("CRPD"). It is focused upon the requirement of Article 12.4 of that Convention that any measure relating to the exercise of legal capacity ensures safeguards to respect "rights, will and preferences". Indeed, "will" was described as "the bedrock of all law" by Wayne Martin, Professor of Philosophy at the University of Essex, and leader of the Essex Autonomy Project, when he described that Project's work on "'Recognition' of the 'will'" at the Project's Summer School on 9th – 11th August 2023. Several participants in the European Law Institute's ("ELI's") current project on "Advance choices" were present, and Professor Martin's comments led to an immediate debate, thereafter continued (and continuing) by email, on relevant questions such as whether an explicit instruction by the granter of an advance choice to override a subsequent vociferous expression of will to the contrary, should be applied so as to do so. Professor Martin quoted Justinian's proposition that "*furiosi nulla voluntas est*". Relevant to both the Essex Autonomy Project and the ELI project is the question whether an expression of will in the absence of adequate capacity to do so renders that expression not evidence of the person's will at all. We add to the deliberations of the two projects this unaddressed question, in the case of Ms Allan's Will, as to whether fundamental error, induced or uninduced, rendered her unilateral expression of "will" contained in her 2019 Will a nullity, and thus in terms of CRPD not an expression of will at all.

Adrian D Ward

[11] A point on which the law of England & Wales is fundamentally different, the difference being an example of one of the basic differences between civil law and common law systems.

Law reform progress report

In this last edition of the Mental Capacity Report forthis year, this is an update on Scottish Government's progress in work following upon its response in June 2023 to the Scottish Mental Health Law Review ("the Scott Review"). Jill Stavert described that response here.

Scottish Government continues major work towards substantially implementing the recommendations of the Scott Review, and has already consulted extensively with stakeholders on its proposed draft Delivery Plan, and on scoping various key areas of work towards achieving delivery. Consultations continue. Consultees, who include both Jill and me, have been asked to keep these discussions, and particularly the associated papers, as confidential, for the obvious reason that discussions are deliberative and papers are drafts which could be changed (perhaps radically). The following is however authorised for dissemination to "wider organisations or other colleagues". I treat all readers of the Report as colleagues!

Scottish Government confirm that work is now underway to establish a new Mental Health and Capacity Reform Programme "to drive changes in legislation, improve support and strengthen accountability for human rights". Scottish Government intends to publish an initial Delivery Plan in early 2024. It will include information about priority work that will be taken forward during the first 18 months of Government's work (from October 2023 to April 2025) to help Government to achieve the Programme's vision and aims. Government also plans to publish a response to the individual recommendations from the Scott Review. Activity is already underway to set up new workstreams to deliver on the initial priorities. Further work will continue in 2024 to develop Government's approach to implementation, its leadership and governance structures, and how it will monitor and report on progress. All of this outlines the law reform agenda for 2024 insofar as relevant to the scope of the Mental Capacity Report.

I would add my own comment that "delivery" is not defined.

Adrian D Ward

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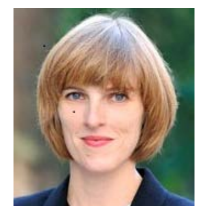

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Adrian will be speaking at the World Congress of Adult Support and Care. This event will be held at the Faculty of Law of the University of Buenos Aires from August 27-30, 2024. For more details, see here.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in February. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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